42314

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Manisha Juthani, MD
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality and Safety Branch

Reviewed & Accepted 1/24/25 CTstudyRNSWA

January 15, 2025

Gina Cambre, Executive Director
Bridges By Epoch At Norwalk
123 Richards Avenue
Norwalk, CT 06854
Via Email: gcambre@bridgesbyepoch.com

Dear Ms. Cambre:

An unannounced visit was made to Bridges By Epoch At Norwalk, on January 2, 2025, by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a complaint investigation survey.

Attached is the violation of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which was noted during the course of the visit. The state violations cannot be edited by the provider in any way.

In accordance with Connecticut General Statutes, section 19a-496, upon a finding of noncompliance with such statutes or regulations, the Department shall issue a written notice of noncompliance to the institution. Not later than ten days after such institution receives a notice of noncompliance, the institution shall submit a plan of correction to the Department in response to the items of noncompliance identified in such notice.

The plan of correction is to be submitted to the Department by January 25, 2025.

The plan of correction shall include:
(1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance;
(2) the date each such corrective measure or change by the institution is effective;
(3) the institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and

(4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

The plan of correction shall be deemed to be the institution's representation of compliance with the identified state statutes or regulations identified in the department's notice of noncompliance. Any institution that fails to submit a plan of correction may be subject to disciplinary action.

You may wish to dispute the violation and you may be provided with the opportunity to be heard. If the violation is not responded to by January 25, 2025, or if a request for a meeting is not made by the stipulated date, the violation shall be deemed admitted.

We do not anticipate making any practitioner referrals at this time.

Please return your response to Elizabeth Heiney, Supervising Nurse Consultant, at Elizabeth.Heiney@ct.gov. Please direct your questions concerning the instructions contained in this letter to Elizabeth Heiney directly at (860) 509-8059. Please do not send another copy via US mail.

Respectfully,

/s/

Elizabeth Heiney, BS, MSN, BC
Supervising Nurse Consultant
Facility Licensing and Investigations Section

EH:csf

c. VL

Complaint #42314

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D105 (e) General requirements for an assisted living services agency (1) and (g) Supervisor of assisted living services (2)(A)(B) and (h) Nursing Services provided by an assisted living service agency (3)(C).

1. Based on review of clinical records, agency documentation, interviews with agency personnel and agency policies for one of two clients (Client #1) in the survey sample with a change in condition, the Assisted Living Services Agency (ALSA) failed to conduct Registered Nurse (RN) assessments as often as necessary based on a client's condition, failed to provide oversight of assigned nursing personnel (LPNs) and ALSA aides in the delivery of services to a client, and failed to meet a client's emergent care needs timely. The findings include:
   a. Client #1 was admitted to the secured memory care agency in 2021 with diagnoses of dementia, anxiety, depression, arthritis, constipation, and high blood pressure.

      The Client's 120-day assessment and service plan dated 04/01/2024, identified Client #1 received nursing services for assessments and medication administration. Client #1 required full assistance from ALSA aides with bathing, grooming, dressing, incontinence care, wheelchair mobility and transfers. Additionally, the Client's service plan identified he/she was at risk for skin breakdown and the Client's skin would be checked during activities of daily living care and any changes of condition would be reported to nursing.

      Review of Client #1's nurse's note dated 08/23/2024, identified the Client was yelling for help and complained of pain to his/her left arm and buttocks. The Client was repositioned and given an Acetaminophen tablet for pain. The Client declined to get out of bed, eat dinner or take his/her evening medications. Licensed Practical Nurse (LPN) #1 notified the Client's responsible person and Supervisor of Assisted Living Services Agency (SALSA).

      Review of Client #1's nurse's note dated 08/25/2024, identified the Client did not eat breakfast or lunch but did drink fluids. Client #1 complained of pain to his/her buttocks and was given an Acetaminophen tablet but continued to yell for help. LPN #2 notified the SALSA and the Client's physician who instructed LPN #2 to call 911 around 1:00 PM. LPN #2 entered the Client's apartment and observed the Client's responsible person was present. Client #1's responsible person requested to speak with the Client's physician by phone.

      Review of the Emergency Medical Services (EMS) report dated 08/25/2024 identified the ambulance was dispatched to the agency at 1:00 PM and arrived at 1:26 PM. The EMS report identified the ALSA staff reported the Client had complained of buttocks pain for one week and was screaming for help all day. The Client's responsible person was present and reported to the EMS personnel that for over a week, the Client was increasingly confused, lethargic, and agitated. The Client was transferred onto a stretcher, became agitated and complained of buttocks pain. Client #1 was transported to the hospital via ambulance on 08/25/2024.

Review of the emergency department physician's note dated 08/25/2024, identified Client #1 arrived at the emergency department by ambulance for increased confusion, buttocks pain, and failure to thrive. The physician indicated that the Client's responsible person reported over the past two weeks, the Client had presented with increased weakness and slurred speech. The responsible person further identified he/she reported Client #1's changes to ALSA staff and was concerned the Client had not been transported to the hospital sooner.

- Observation and review of photographs of Client #1's skin taken on 08/25/2024 in the emergency department upon the Client's arrival, identified an opened wound to the coccyx and red/purple bruising to the lower back, hips and posterior thighs.

Interview and review of Client #1's clinical record with Executive Director and SALSA on 01/02/2025 at 12:30 PM, identified the Client's responsible person had notified the Executive Director around 08/23/2024 or 08/24/2024 of Client #1's slurred speech and weakness and was concerned the Client may have had a cardiovascular accident (stroke). The SALSA failed to identify the Client had a RN assessment after the Client's responsible person reported Client #1's change in condition and failed to identify the ALSA aide staff reported Client #1's change in condition timely.

Review of the agency's Change of Status policy, identified when there was a noticeable change in the mental, medical, or functional status of a client, the Wellness Director assesses the client's condition and documents the findings in the client record. If the change is in the client's functional abilities, a complete assessment update will be completed.

Review of the agency's Client Assessment policy identified the assessment process is essential to providing quality services to assisted living clients. It is the responsibility of the Wellness Director (nurse) to perform the assessment and initiate and update the service plan. It is completed pre-move in and reassessed every 120-days and after a significant change.

Plan of Correction for Violation #1:

Reviewed & Accepted 1/24/25 CT Surveyor RW 3DC

Plan of Correction
The Bridges by Epoch at Norwalk
January 23, 2025

Violation #1: The following is a plan of correction for violations of the Regulations of Connecticut State Agencies Section 19-13-D105 (e) General requirements for an assisted living services agency (1) and/or (g) Supervisor of assisted living services (2)(A)(B) and/ (h) Nursing Services provided by an assisted living service agency (3)(C).

Prevention of Recurrence:
(1). Re- Training of SALSA and RN Designee on Change of Condition/Coordinating nursing and ALA services/Supervising nursing and assisted living aides care: The SALSA and RN Designee was re-trained and re-educated on the policies/procedures as it relates to the resident change of condition. As the RNs, the SALSA and RN Designee are responsible for maintaining change of condition and for updating care plans as it pertains to any resident changes. Documentation included creating a new change of condition assessment and for communicating with the care givers once the change occurs. The documentation of change of condition included notification of the legal representative and the physician. Re-training the SALSA and RN Designee on the policy related to the timing of the assessment on move in, on the 120-day assessments and on the change of condition assessments. The SALSA and RN Designee are responsible for coordinating and managing all nursing and assisted living aide services. The SALSA and RN Designee are responsible for the supervision of nursing and the assisted living aide personnel.

Date of Completion:
(1) Completed on January 22, 2025

Monitoring Quality Assessment & Improvement:
(1). For the next 90 days (beginning on 1/22/25) assessments, progress notes, communication reports, daily huddles incident reports, tracking reports, manager on duty reports and verbal communication will be utilized to identify and resident change of condition and the required communication of such.

Person Responsible:
(1). Executive Director
(2). VP Wellness

Accepted 1/24/25 ET Henry RN SNC Pg. 2

Prevention of Recurrence:
(1). LPN Education: A Formal re-education for the LPN nurse staff to inform the RN staff of any potential change in condition. The LPN staff, per state regulations, is not able to identify and assess any change of condition. Rather, the LPN will report to the RN, and it will be the RN's responsibility to determine if a change of condition occurred. The LPNs role is merely to report to the RN for further assessment.

Date of Completion:
(1). Completion date February 10, 2025

Monitoring Quality Assessment & Improvement:

(1). For the next 90 days (beginning on February 10, 2025) assessments, progress notes, daily huddles, communication reports, incident reports, tracking reports, manager on duty reports and verbal communication will be utilized to identify a resident change of condition and the required communication of such. The RN will work with the LPNs to identify and to determine whether an RN assessment is required for a change of condition assessment.

Person Responsible:
(1). SALSA
(2). Executive Director

Prevention of Recurrence:
(1). Assisted Living Aide Education: A re-education of the assisted living aides so that they can report any changes to the LPN/RN staff. The RN staff, per state regulations, can identify and assess any change of condition. The assisted living aide will report to the LPNs/RNs, but it will be the RN's responsibility to determine if a change of condition occurred. A review of the care givers responsibility and care plan in identifying when residents are not feeling well or not doing well.

Date of Completion:
(1). Completion date February 15, 2025

Monitoring Quality Assessment & Improvement:

(1). For the next 90 days (beginning on February 15, 2025) assessments, progress notes, daily huddles, communication reports, incident reports, tracking reports, manager on duty reports and verbal communication will be utilized to identify a resident change of condition and the required communication of such. The RN will work with the LPNs to identify and to determine whether an RN assessment is required for a change of condition assessment.

Person Responsible:
(1). SALSA
(2). Executive Director